Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

APPLICATION FOR WASHINGTON STATE TAKE CHARGE FAMILY PLANNING SERVICES

Note: This application can ONLY be completed at a TAKE CHARGE Provider's office.
Please Print

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH (MM/DD/YYYY)	☐ Male ☐ Female	SOCIAL SECURITY NUMBER (MANDATORY IF 18 YEARS OLD OR OLDER)

STREET ADDRESS WHERE YOU LIVE	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT, OR USE CLINIC ADDRESS)	CITY	STATE	ZIP CODE

If you are a teen/young adult or domestic violence victim and do not want parents/guardian or domestic violence perpetrator to know you are using family planning services, check "Yes" to Confidential Use of Services. If not, then check "No". If yes, also complete Confidential Address, E-mail Address and Telephone Number.

CONFIDENTIAL USE OF SERVICES ☐ Yes ☐ No	CONFIDENTIAL ADDRESS	E-MAIL ADDRESS	TELEPHONE NUMBER

MEDICAL NEED FOR FAMILY PLANNING

1. **Male or Female Applicant** — Yes ☐ No ☐
   Do you intend to use a birth control method to prevent an unintended pregnancy?
   If "no", you are not eligible for TAKE CHARGE. (Stop here - discuss payment for services with your provider).

2. **Female Applicant** — Yes ☐ No ☐ Don't Know ☐
   Do you have **any** reason to believe you could be pregnant now?
   If "yes" or "don't know", stop here and ask for a pregnancy test. If pregnancy test is negative, continue. If you are pregnant you are not eligible for Take Charge. You may be eligible for other medical coverage. Contact your local Community Services Office (CSO).

HEALTH INSURANCE

Do you have a DSHS Medical ID card? Yes ☐ No ☐
If "yes", you are ineligible for TAKE CHARGE. Your Provider will bill the state using your coupon.

Do you have health insurance? Yes ☐ No ☐
Name of health insurance company: _____

Your health insurance will be billed before TAKE CHARGE unless you are a domestic violence victim who is covered under his/her spouse's health insurance and don't want them to know you are using Family Planning services. You may request the provider not bill your primary insurance company by checking the box below.

☐ I am a domestic violence survivor/victim.

Your health insurance will be billed before TAKE CHARGE unless you are a young adult who is covered under his/her parent(s)/guardian(s) health insurance and don't want them to know you are using Family Planning services. You may request the provider not bill your primary insurance company by checking the box below.

☐ I am a young adult who is covered under my parent's/guardian's health insurance but don't want parents insurance billed due to confidentiality.

CITIZENSHIP

Are you a U.S. citizen or U.S. National? ☐ Yes ☐ No

If "no", please give a copy of your INS paperwork and date you permanently entered the U.S. to the provider.
Note: If you are not a legal permanent resident, U.S. citizen or U.S. National, you do not qualify for TAKE CHARGE.

RESIDENCY

Are you a Washington State resident or a college student that intends to remain in Washington after school? ☐ Yes ☐ No

If "no", you are not eligible for TAKE CHARGE. (Stop here - discuss payment for services with your provider).

ETHNICITY/RACE

Are you Hispanic or Latino? ☐ Yes ☐ No ☐ Don't Know ☐ Prefer not to answer

Which one or more of the following would you say is your race? (Check or write any or all that apply)

- ☐ White
- ☐ African American/Black
- ☐ Asian
- ☐ Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Other (Please specify): _____
- ☐ Prefer not to answer

INCOME REQUIREMENTS AND FAMILY SIZE

Monthly Earned Income

1. Enter your GROSS wages and tips (before taxes and deductions are taken out) for the last monthly pay period, or if you are a young adult living at home or at college and your parents know you are receiving Family Planning Care, enter your parents GROSS wages and tips for the last monthly pay period. _____
2. If self-employed, estimate your anticipated net monthly income after business expenses. _____
3. **If you are married, enter spouse's gross monthly wages.** (plus) + _____
4. Subtotal earned monthly wages. (subtotal) = _____
5. Subtract $90 if you work and another $90 if your spouse works. (minus) - _____
   (Note: If you make less than $90 a month, just subtract amount you make)
6. Subtract any monthly work-related child or adult care payments (minus) - _____
7. Subtract all monthly court-ordered Child Support payments for a child living outside the home. (minus) - _____
8. Total earned income **(Earned Income Subtotal)** _____
9. <u>You and your Spouse's Monthly Unearned Income</u>

	Amount Per Month		Amount Per Month
Child Support or Alimony		Veteran's Benefits	
Social Security Benefits		Labor & Industries Benefits	
Unemployment Benefits		Military Allotments	
Interest from Bank Account		Other	

10. Total Unearned Income: **(Unearned Income Subtotal)** _____
11. Total Monthly Income: **(Total of #8 & #10)** _____
12. Family Size: (Include you, your spouse and any dependent children. If young adult living with parents or at college and your parents know you are receiving Family Planning care, how many people are supported by your parents, including parents)? _____
13. If you are reporting zero income, explain how you are meeting your needs.

_____

_____

_____

_____

I have read and understood the information in this application. I declare, under penalty of perjury all information I gave in this application is true, correct and complete to the best of my knowledge. If I am not eligible for TAKE CHARGE all family planning services costs are my responsibility.

SIGNATURE OF APPLICANT	DATE

If you need more information on other services, go to your local Community Services Office.

FOR CLINIC USE - MUST BE COMPLETED

NAME OF CLINIC/PROVIDER WHERE CLIENT IS APPLYING		
NAME OF STAFF PERSON ASSISTING CLIENT WITH APPLICATION	TELEPHONE NUMBER	FAX NUMBER